DISABILITY BENEFITS APPEAL REQUEST FORM

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

You have the right to file an appeal of the OPERS Board of Trustees' denial or termination of your disability benefit. Please note, OPERS' third-party administrator may be contacting you regarding your appeal.

STEP 1: Member's Personal Information

Social Security Number ___ — ___ — ____ **-OR-** OPERS ID

First Name MI Last Name

Date of Birth ___/___/____ Gender: ◯ Male ◯ Female

Address

City State ZIP Code

Home Phone Number ___ — ___ — ____ Work Phone Number ___ — ___ — ____

Cell Phone Number ___ — ___ — ____

Preferred Telephone Number for Contact: ◯ Home ◯ Work ◯ Cell

Preferred Time to Call: ◯ Morning ◯ Afternoon ◯ Evening

Preferred Language of Communication:

E-mail Address

See next page

STEP 2: Appeal Request

Please mark the following box if applicable:

☐ Appeal Board's Decision - I am choosing to appeal the retirement board's decision to deny/terminate my disability benefit. I will forward my completed Report of Physician form and any additional objective medical evidence to support my claim.

STEP 3: Appeal Extension Request

Please mark the following box if applicable:

☐ Extension Request - I request an additional 45 days to submit my completed Report of Physician form and any additional objective medical evidence to support my claim.

STEP 4: Member's Acknowledgment

HIPAA DISCLOSURE:
I authorize any licensed physician, medical provider, medical facility or provider of health care or similar entity to release any and all of the following information to OPERS or their third party administrators:

Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OPERS and their third party administrators.

I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying OPERS.

I understand that revoking this Authorization may impair necessary processing of my OPERS benefits.

I understand and acknowledge that my appeal request will not be reviewed and decided upon by the OPERS Board of Trustees until the expiration of the time frame allowed for me to submit my completed Report of Physician form and objective medical evidence supporting my claim.

Member Signature _____ Today's Date ____/____/____

Do not print or type name

OPERS